Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TEXAS HEALTH ARLINGTON MEMORIAL HOSPITAL 500 E BORDER 11TH FLOOR ARLINGTON TX 76010	MFDR Tracking #: M4-11-1564-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was seen at our facility emergency room on 10/10/10 as a result of a work related injury on 5/8/10. We billed this patient's workers comp insurance, Texas Mutual and received a denial which stated this is not treating doctor approved treatment, that the documentation does not support an emergency, and that this provider was not certified to be paid for this procedure on this date of service. We filed a request for reconsideration to Texas Mutual and received another denial. Per Sec. 413.014(b), treatments and services for a medical emergency do not require express preauthorization. We believe a fair resolution for this complaint would be for Texas Mutual to process this bill per the Workers Compensation State Fee Schedule and issue the proper payment."

Amount in Dispute: $1,363.32

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant went to the requestor's emergency department on 10/10/20 [sic]. Upon receipt of the requestor's bill Texas Mutual reviewed the attached documentation and from that initial review denied payment and denied payment after the request for reconsideration for the following reasons. In order for the requestor to be reimbursed Texas Mutual argues one or the other of the two following conditions must be met: the treating doctor needed to refer the claimant to the emergency department or the clinical situation should have been emergent. The requestor's documentation indicates the claimant last contacted the treating doctor nine days prior to the disputed date. This eliminates one condition. The requestor's documentation reports the severity of the claimant's clinical condition as "moderate." Further, the requestor conducted no diagnostic testing, i.e. imaging studies, blood work, urinalysis, etc. And finally, the requestor documented the claimant's physical assessment as a "benign exam." This eliminates the second condition."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/10/2010	CPT Codes 96374, 96375, 96376, 99283, J1170, J7040, Rev Code 250	N/A	$1,363.32	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation

medical bills for reimbursement.

3. 28 Tex. Admin. Code §133.2(3) defines emergency, either medical or mental health emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 11/30/2010:

   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 242 – Not treating doctor approved treatment.
   - 724 – No additional payment after a reconsideration of services…
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.

Issues

1. Does emergency room treatment have to be approved by the treating doctor?
2. Does the submitted documentation support an emergency?

Findings

1. The respondent incorrectly denied the emergency room charges using denial codes "CAC-B7" and "242". Rule 180.22 states at (c) "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency…" The respondent believes that the treating doctor needed to refer the claimant to the emergency department or the clinical situation should have been emergent. Review of the documentation, submitted by the respondent, shows that the claimant came to the emergency department at 4:09. Further review of the submitted documentation shows that the arrival time of the claimant to the emergency department was in the morning as the discharge instructions show the time of discharge to be 7:48:27 AM.

2. The respondent has denied the emergency room treatment using denial code "899", stating that the documentation and file review did not support an emergency in accordance with Rule 133.2. According to Division Rule 133.2(3)(A) "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part". Review of the submitted ED Physician Note documents the chief complaint as back pain; onset/duration of symptom as 9 weeks; the severity is moderate; and the context of events as the "Pt c/o low back pain radiating to left more than right buttock/hip/knee areas. No bowel or bladder incontinence. No saddle anesthesia. No new motor weakness." The report also documents that the patient was alert, no distress and not anxious. The ED Physician Notes also documents: "Benign exam. Non toxic." Further review of the documentation does not show any testing being done on the patient during the course of the emergency department visit. The documentation does not meet the requirements of Rule 133.2(3)(A); therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	03/29/11 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.